		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040410

Facility Name: Elmwood Care

Address: 7733 W. Grand Ave . (Number) Elmwood Park (City) 60635 (Zip Code)

County: Cook

Telephone Number: (708) 452-9200 **Fax #** (708) 452-9294

IDPA ID Number: 363868389001

Date of Initial License for Current Owners: 04/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Cary C. Buxbaum, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	245	Skilled (SNF)	245	89,670	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	245	TOTALS	245	89,670	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	54,235	5,054	12,498	71,787	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	54,235	5,054	12,498	71,787	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.06%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 64 and days of care provided 6,073

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	282,545	64,070	39,996	386,611		386,611	(24,073)	362,538			1
2	Food Purchase		354,022		354,022	(41,109)	312,913	(248)	312,665			2
3	Housekeeping	228,069	54,451		282,520		282,520	741	283,261			3
4	Laundry	77,806	38,433		116,239		116,239		116,239			4
5	Heat and Other Utilities			191,902	191,902		191,902	(1,393)	190,509			5
6	Maintenance	53,298	17,537	125,962	196,797		196,797	(25,302)	171,495			6
7	Other (specify):*							5,152	5,152			7
8	**TOTAL General Services**	641,718	528,513	357,860	1,528,091	(41,109)	1,486,982	(45,123)	1,441,859			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	2,684,227	268,243	549,509	3,501,979		3,501,979	(76,272)	3,425,707			10
10a	Therapy	63,528	606	25,051	89,185		89,185		89,185			10a
11	Activities	115,468	5,543	2,264	123,275		123,275		123,275			11
12	Social Services	105,151		2,313	107,464		107,464		107,464			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							3,565	3,565			15
16	**TOTAL Health Care and Programs**	2,968,374	274,392	593,537	3,836,303		3,836,303	(72,707)	3,763,596			16
	C. General Administration											
17	Administrative	161,158		578,104	739,262		739,262	(499,269)	239,993			17
18	Directors Fees											18
19	Professional Services			177,200	177,200	(10,574)	166,626	(139,118)	27,508			19
20	Dues, Fees, Subscriptions & Promotions			80,140	80,140		80,140	(44,878)	35,262			20
21	Clerical & General Office Expenses	92,064	29,264	199,201	320,529		320,529	(94,313)	226,216			21
22	Employee Benefits & Payroll Taxes			611,152	611,152	41,109	652,261	(683)	651,578			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,932	5,932		5,932	507	6,439			24
25	Other Admin. Staff Transportation			3,120	3,120		3,120	2,892	6,012			25
26	Insurance-Prop.Liab.Malpractice			199,102	199,102		199,102	1,176	200,278			26
27	Other (specify):*							23,261	23,261			27
28	**TOTAL General Administration**	253,222	29,264	1,853,951	2,136,437	30,535	2,166,972	(750,426)	1,416,547			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,863,314	832,169	2,805,348	7,500,831	(10,574)	7,490,257	(868,255)	6,622,002			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Elmwood Care #0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			140,218	140,218		140,218	326,386	466,604			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			63,627	63,627		63,627	763,879	827,506			32
33	Real Estate Taxes			398,084	398,084	10,574	408,658	53,422	462,080			33
34	Rent-Facility & Grounds			756,600	756,600		756,600	(756,600)				34
35	Rent-Equipment & Vehicles			5,792	5,792		5,792	4,145	9,937			35
36	Other (specify):*							19,385	19,385			36
37	TOTAL Ownership			1,364,321	1,364,321	10,574	1,374,895	410,617	1,785,512			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	149,205	420,141	528,367	1,097,713		1,097,713	(59,560)	1,038,153			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			134,506	134,506		134,506		134,506			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	149,205	420,141	662,873	1,232,219		1,232,219	(59,560)	1,172,659			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,012,519	1,252,310	4,832,542	10,097,371	(0)	10,097,371	(517,198)	9,580,173			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	39,515	30		9
10	Interest and Other Investment Income	(384)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(248)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,595)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(146,854)	21		24
25	Fund Raising, Advertising and Promotional	(24,368)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(15,575)	20		28
29	Other-Attach Schedule	(57,810)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (207,319)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(309,879)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (309,879)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (517,198)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Elmwood Care

ID# 0040410

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc. Income	$ (52)	21	1
2	Perscription Drugs - VA	(6,246)	10	2
3	Purchased Services - VA	(217)	10	3
4	Theft & Damage Loss	(1,642)	21	4
5	COPE Dues	(3,791)	20	5
6	PPA - Contract Nursing	(9,064)	10	6
7	PPA - Enteral Supplies	(7,000)	39	7
8	Cable TV	(3,842)	05	8
9	Non-Allowable Legal Fees	(20,134)	19	9
10	Capitalized R&M	(5,822)	06	10
11				11
12				12
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99				**99**
100				**100**
101	Total	**(57,810)**		**101**

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary					(18,209)	(5,864)						(24,073)	1
2	Food Purchase	(248)											(248)	2
3	Housekeeping			741									741	3
4	Laundry													4
5	Heat and Other Utilities	(3,842)		971	1,478								(1,393)	5
6	Maintenance	(5,822)		707	(15,330)		(1,336)		(3,521)				(25,302)	6
7	Other (specify):*				1,003	1,422	2,727						5,152	7
8	**TOTAL General Services**	(9,912)		2,419	(12,849)	(16,787)	(4,473)		(3,521)				(45,123)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(15,527)			(29,693)				(31,052)				(76,272)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				3,565								3,565	15
16	**TOTAL Health Care and Programs**	(15,527)			(26,128)				(31,052)				(72,707)	16
	C. General Administration													
17	Administrative			19,041	(75,895)	(438,083)	(4,320)			(12)			(499,269)	17
18	Directors Fees													18
19	Professional Services	(20,134)		(113,962)	343	14,483	(19,848)						(139,118)	19
20	Fees, Subscriptions & Promotions	(45,329)		233	218								(44,878)	20
21	Clerical & General Office Expenses	(148,548)		65,691	(11,456)								(94,313)	21
22	Employee Benefits & Payroll Taxes							(673)		(10)			(683)	22
23	Inservice Training & Education													23
24	Travel and Seminar			186	321								507	24
25	Other Admin. Staff Transportation			640	2,252								2,892	25
26	Insurance-Prop.Liab.Malpractice			464	712								1,176	26
27	Other (specify):*			11,255	4,201	7,805							23,261	27
28	**TOTAL General Administration**	(214,012)		(16,452)	(79,304)	(415,795)	(24,168)	(673)		(22)			(750,426)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(239,450)		(14,033)	(118,281)	(432,582)	(28,641)	(673)	(34,573)	(22)			(868,255)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	39,515	257,442	2,294	27,135								326,386	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(384)	756,600	415	7,248								763,879	32
33	Real Estate Taxes		46,669	2,500	4,253								53,422	33
34	Rent-Facility & Grounds		(756,600)										(756,600)	34
35	Rent-Equipment & Vehicles			2,411	1,734								4,145	35
36	Other (specify):*		19,385										19,385	36
37	**TOTAL Ownership**	39,131	323,496	7,620	40,370								410,617	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(7,000)			(52,560)								(59,560)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(7,000)			(52,560)								(59,560)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(207,319)	323,496	(6,413)	(130,471)	(432,582)	(28,641)	(673)	(34,573)	(22)			(517,198)	45

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent - Base	$ 756,600	Elmwood Building, LLC		$	$ (756,600)	1
2	V	33	Rent - Taxes	374,288	Elmwood Building, LLC		420,957	46,669	2
3	V	36	Amortization		Elmwood Building, LLC		19,385	19,385	3
4	V	30	Depreciation		Elmwood Building, LLC		257,442	257,442	4
5	V	32	Interest Expense		Elmwood Building, LLC		756,600	756,600	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,130,888			$ 1,454,384	$ * 323,496	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	PREFERRED BOOKKEEPING	100.00%	$ 741	$ 741	15
16	V	5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	971	971	16
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	707	707	17
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	19,041	19,041	18
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,538	1,538	19
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	233	233	20
21	V	21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	65,691	65,691	21
22	V	24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	186	186	22
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	640	640	23
24	V	26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	464	464	24
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	11,255	11,255	25
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	2,294	2,294	26
27	V	32	INTEREST		PREFERRED BOOKKEEPING	100.00%	415	415	27
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	2,500	2,500	28
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,411	2,411	29
30	V								30
31	V								31
32	V	19	ACCOUNT./BOOKKEEPING	115,500	PREFERRED BOOKKEEPING	100.00%		(115,500)	32
33	V	19	COMPUTER	5,880	PREFERRED BOOKKEEPING	100.00%	5,880		33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 121,380			$ 114,967	$ * (6,413)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.I.R. MANAGEMENT, INC.	100.00%	$ 1,478	$ 1,478	15
16	V	6	REPAIRS AND MAINT.	22,056	S.I.R. MANAGEMENT, INC.	100.00%	6,726	(15,330)	16
17	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,003	1,003	17
18	V	10	NURSING	48,516	S.I.R. MANAGEMENT, INC.	100.00%	18,823	(29,693)	18
19	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,565	3,565	19
20	V	17	ADMINISTRATIVE	85,968	S.I.R. MANAGEMENT, INC.	100.00%	10,073	(75,895)	20
21	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	343	343	21
22	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	218	218	22
23	V	21	CLERICAL & GENERAL	24,996	S.I.R. MANAGEMENT, INC.	100.00%	13,540	(11,456)	23
24	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	321	321	24
25	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	2,252	2,252	25
26	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	712	712	26
27	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,201	4,201	27
28	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	2,842	2,842	28
29	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	950	950	29
30	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	4,253	4,253	30
31	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	1,734	1,734	31
32	V								32
33	V	39	LEASED EQUIPMENT	52,560	S.I.R. MANAGEMENT, INC.	100.00%		(52,560)	33
34	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	24,293	24,293	34
35	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	6,298	6,298	35
36	V								36
37	V								37
38	V								38
39	Total			$ 234,096			$ 103,625	$ * (130,471)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 24,996	S.I.R. MANAGEMENT, INC.	100.00%	$ 6,787	$ (18,209)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,422	1,422	16
17	V	17	ADMIN./LEGAL SALARIES	487,816	S.I.R. MANAGEMENT, INC.	100.00%	49,733	(438,083)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	14,483	14,483	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	7,805	7,805	19
20	V								20
21	V	17	ADMIN. SALARY-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			21
22	V	6	REPAIRS & MAINT.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			22
23	V	21	CLERICAL & GEN.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			23
24	V	26	AUTO INSURANCE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			24
25	V	27	EMP. BENEFITS-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			25
26	V	35	AUTO LEASE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			26
27	V								27
28	V	17	ADMIN. SALARY-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			28
29	V	21	CLERICAL & GEN.-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			29
30	V	26	AUTO INSURANCE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			30
31	V	27	EMP. BENEFITS-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			31
32	V	35	AUTO LEASE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 512,812			$ 80,230	$ * (432,582)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	SPECIAL REHAB		S.I.R. MANAGEMENT, INC.	100.00%		$	15
16	V	15	EMP. BEN.-H. CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%			16
17	V								17
18	V	6	REPAIRS AND MAINT.	5,436	S.I.R. MANAGEMENT, INC.	100.00%	4,100	(1,336)	18
19	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	812	812	19
20	V								20
21	V								21
22	V	1	DIETICIAN SALARIES	15,000	S.I.R. MANAGEMENT, INC.	100.00%	9,136	(5,864)	22
23	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,915	1,915	23
24	V								24
25	V	19	LEGAL FEES	19,848	S.I.R. MANAGEMENT, INC.	100.00%		(19,848)	25
26	V								26
27	V	17	FEES	4,320	S.I.R. MANAGEMENT, INC.	100.00%		(4,320)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 44,604			$ 15,963	$ * (28,641)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 123,886	$ 123,886	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	124,559	CCS EMPLOYEE BENEFIT GROUP	100.00%		(124,559)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 124,559			$ 123,886	$ * (673)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$	XCEL MEDICAL SUPPLY, LLC	100.00%	$	$	15
16	V	02	FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03	HOUSEKEEPING		XCEL MEDICAL SUPPLY, LLC	100.00%			17
18	V	04	LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%			18
19	V	06	REPAIRS & MAINTENANCE	23,736	XCEL MEDICAL SUPPLY, LLC	100.00%	20,214	(3,521)	19
20	V	10	NURSING	209,301	XCEL MEDICAL SUPPLY, LLC	100.00%	178,249	(31,052)	20
21	V	10A	THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	12	SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21	CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22	EMPLOYEE BENEFITS		XCEL MEDICAL SUPPLY, LLC	100.00%			24
25	V	39	ANCILLARY		XCEL MEDICAL SUPPLY, LLC	100.00%			25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 233,036			$ 198,463	$ * (34,573)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	HEALTH INSURANCE	$ 13,840	ECM OWNERS COUNCIL	100.00%	$ 13,698	$ (142)	15
16	V	17	ADMINISTRATOR SALARY	7,920	ECM OWNERS COUNCIL	100.00%	7,908	(12)	16
17	V	22	PAYROLL TAXES	600	ECM OWNERS COUNCIL	100.00%	732	132	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 22,360			$ 22,338	$ * (22)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Nenita Guzman	Relative	Dietary	0%	See Attached	5.29	10.58%	Alloc Salary	$ 6,787	1-7	1
2	Louise Bergthold	Shareholder	Administrative	4.90%	See Attached	5.82	10.58%	Alloc Salary	18,600	17-7	2
3	Tom Winter	Shareholder	Administrative	1.43%	See Attached	7.06	11.77%	Alloc Salary	19,041	17-7	3
4	Jeff Oravec	Shareholder	Administrative	0.41%	See Attached	4.23	10.58%	Alloc Salary	10,662	17-7	4
5	Joey Abramchik	Shareholder	Administrative	2.04%	See Attached	4.76	10.58%	Alloc Salary	14,483	17-7	5
6	Stuart Sikes	Shareholder	Administrative	0.82%	See Attached	4.23	10.58%	Alloc Salary	11,937	17-7	6
7	Lori Barrish	Shareholder	Administrator	2.04%	None	40.00	100.00%	Salary	92,357	17-1	7
8	Eric Rothner	Relative	Administrative	0%	See Attached	0.81	1.76%	Alloc Salary	9,947	17-7	8
9	Adam Vales	Relative	Clerical	0%	See Attached	0.81	2.03%	Alloc Salary	835	22-7	9
10											10
11											11
12											12
13								TOTAL	$ 184,649		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREFERRED BOOKKEEPING SERVICES
Street Address: 4100 WEST PRATT AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 674-5200
Fax Number: (847) 674-5267

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	927,958	10	$ 5,955	$	115,500	$ 741	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	927,958	10	7,801		115,500	971	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	927,958	10	5,680		115,500	707	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	927,958	10	152,983	152,983	115,500	19,041	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	927,958	10	12,360		115,500	1,538	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	927,958	10	1,874		115,500	233	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	927,958	10	527,777	466,233	115,500	65,691	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	927,958	10	1,493		115,500	186	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	927,958	10	5,142		115,500	640	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	927,958	10	3,729		115,500	464	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	927,958	10	90,428		115,500	11,255	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	927,958	10	18,431		115,500	2,294	12
13	32	INTEREST	BOOK./ACCNT.INCOME	927,958	10	3,338		115,500	415	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	927,958	10	20,087		115,500	2,500	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	927,958	10	19,368		115,500	2,411	15
16										16
17										17
18										18
19	19	COMPUTER	DIRECT ALLOCATION						5,880	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 876,446	$ 619,216		$ 114,967	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	678,909	11	$ 13,981	$	71,787	$ 1,478	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	678,909	11	63,606	46,253	71,787	6,726	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	678,909	11	9,483		71,787	1,003	3
4	10	NURSING	PATIENT DAYS	678,909	11	178,013	178,013	71,787	18,823	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	678,909	11	33,716		71,787	3,565	5
6	17	ADMINISTRATIVE	PATIENT DAYS	678,909	11	95,266	95,266	71,787	10,073	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	678,909	11	3,242		71,787	343	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	678,909	11	2,062		71,787	218	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	678,909	11	128,049	90,910	71,787	13,540	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	678,909	11	3,040		71,787	321	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	678,909	11	21,297		71,787	2,252	11
12	26	INSURANCE	PATIENT DAYS	678,909	11	6,736		71,787	712	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	678,909	11	39,734		71,787	4,201	13
14	30	DEPRECIATION	PATIENT DAYS	678,909	11	26,873		71,787	2,842	14
15	32	INTEREST	PATIENT DAYS	678,909	11	8,988		71,787	950	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	678,909	11	40,220		71,787	4,253	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	678,909	11	16,401		71,787	1,734	17
18										18
19	39	LEASED EQUIPMENT	LEASING INCOME	52,560	1			52,560		19
20	30	DEPRECIATION	LEASING INCOME	52,560	1	24,293		52,560	24,293	20
21	32	INTEREST	LEASING INCOME	52,560	1	6,298		52,560	6,298	21
22										22
23										23
24										24
25	TOTALS					$ 721,298	$ 410,443		$ 103,625	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	678,909	11	$ 64,183	$ 64,183	71,787	$ 6,787	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	678,909	11	13,453		71,787	1,422	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	678,909	11	470,339	470,339	71,787	49,733	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	678,909	11	136,972		71,787	14,483	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	678,909	11	73,815		71,787	7,805	5
6										6
7	17	ADMIN. SALARY-B. BARRISH	AVG HRS WKD	30	4	155,406	155,406			7
8	6	REPAIRS & MAINT.-B. BARRIS	AVG HRS WKD	30	4	1,462				8
9	21	CLERICAL & GEN.-B. BARRISI	AVG HRS WKD	30	4	1,426				9
10	26	AUTO INSURANCE-B. BARRISI	AVG HRS WKD	30	4	733				10
11	27	EMP. BENEFITS-B. BARRISH	AVG HRS WKD	30	4	32,115				11
12	35	AUTO LEASE-B. BARRISH	AVG HRS WKD	30	4	16,634				12
13										13
14	17	ADMIN. SALARY-M. GIANNINI	AVG HRS WKD	30	4	150,673	150,673			14
15	21	CLERICAL & GEN.-M. GIANNI	AVG HRS WKD	30	4	560				15
16	26	AUTO INSURANCE-M. GIANNI	AVG HRS WKD	30	4	726				16
17	27	EMP. BENEFITS-M. GIANNINI	AVG HRS WKD	30	4	31,946				17
18	35	AUTO LEASE-M. GIANNINI	AVG HRS WKD	30	4	6,756				18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,157,199	$ 840,601		$ 80,230	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	SPECIAL REHAB	SPECIAL REHAB INC.	107,736	7	$ 63,630	$ 63,630		$	1
2	15	EMP. BEN.-H. CARE & PROG.	SPECIAL REHAB INC.	107,736	7	13,337				2
3										3
4	6	REPAIRS AND MAINT.	MAINTENANCE INC.	143,028	11	107,866	107,866	5,436	4,100	4
5	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	143,028	11	21,371		5,436	812	5
6										6
7										7
8	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	76,377	76,377	15,000	9,136	8
9	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	16,008		15,000	1,915	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 298,589	$ 247,873		$ 15,963	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURA	DIRECT ALLOCATION			$	$		$ 123,886	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 123,886	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$	1
2	02	FOOD	Direct Allocation							2
3	03	HOUSEKEEPING	Direct Allocation							3
4	04	LAUNDRY	Direct Allocation							4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						20,214	5
6	10	NURSING	Direct Allocation						178,249	6
7	10A	THERAPY	Direct Allocation							7
8	12	SOCIAL SERVICE	Direct Allocation							8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation							9
10	22	EMPLOYEE BENEFITS	Direct Allocation							10
11	39	ANCILLARY	Direct Allocation							11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 198,463	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ECM OWNERS COUNCIL
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60646
Phone Number: (847)676-2026
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	HEALTH INSURANCE	DIRECT ALLOCATION		4	$	$		$ 13,698	1
2	17	ADMINISTRATOR SALARY	DIRECT ALLOCATION		4				7,908	2
3	22	PAYROLL TAXES	DIRECT ALLOCATION		4				732	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 22,338	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	LOC - SIR Management		X					2,245,000			820,227	6
7	Allocated From Preferred		X								415	7
8	See Supplemental Schedule										7,248	8
9	TOTAL Facility Related						$	$ 2,245,000			$ 827,890	9
	B. Non-Facility Related*											
10	Interest Income		X								(384)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (384)	14
15	TOTALS (line 9+line14)						$	$ 2,245,000			$ 827,506	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated From SIR		X				$	$			$ 7,248	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										7,248	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	470,384	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	482,091	2
3. Under or (over) accrual (line 2 minus line 1).	$	11,707	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	439,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.	$	10,574	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 23,796 For 1999 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	462,080	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	461,646	8
	2000	435,020	9
	2001	410,298	10
	2002	418,390	11
	2003	428,669	12

Note: The beginning accrual has been adjusted by $41,384 to reflect the transfer of net escrow deposits.

Appeal Fees: $7,932 For Direct Appeal Of 1999 Real Estate Taxes
$2,500 Real Estate Appraisal Fee
$142.72 Allocated From SIR Properties

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elmwood Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040410

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-25-323-003-0000	Long Term Care Property	$ 118,252.48	$ 118,252.48
2.	12-25-323-004-0000	Long Term Care Property	$ 117,918.32	$ 117,918.32
3.	12-25-323-005-0000	Long Term Care Property	$ 184,556.08	$ 184,556.08
4.	12-25-324-001-0000	Long Term Care Property	$ 5,654.57	$ 5,654.57
5.	12-25-324-002-0000	Long Term Care Property	$ 2,287.10	$ 2,287.10
6.	Allocated From SIR Properties	Home Office	$ 56,317.44	$ 6,319.59
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 484,985.99	$ 434,988.14

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elmwood Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040410

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,565 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1993	$ 627,991	1
2	Facility		1998	100,000	2
3	TOTALS			$ 727,991	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	129,203		20	6,460	6,460	72,905	9
10	Various			1994	49,738		20	2,487	2,487	26,220	10
11	Various			1995	167,102		20	8,357	8,357	79,669	11
12	Various			1996	136,090		20	6,804	(6,804)	56,902	12
13	Various			1997	16,180		20	809	809	6,106	13
14	Various			1998	161,911		20	9,183	9,183	60,852	14
15	Various			1999	138,019		20	6,902	6,902	37,679	15
16	Various			2000	67,583		20	3,382	3,382	15,080	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
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29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
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62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		10,419,509	257,442		297,700	40,258	3,082,449	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		91,281	3,097		3,597	500	34,219	68
69	Financial Statement Depreciation			140,218			(140,218)		69
70	TOTAL (lines 4 thru 69)		$ 11,376,616	$ 400,757		$ 345,681	$ (68,684)	$ 3,472,081	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 11,376,616	$ 400,757		$ 345,681	$ (55,076)	$ 3,472,081	1
2	Roofing	2001	46,330		20	2,317	2,317	9,267	2
3	Sewer Work	2001	3,800		20	190	190	681	3
4	Roofing	2001	12,940		20	647	647	2,211	4
5	Wet Work	2001	26,148		20	1,307	1,307	4,031	5
6	Hot Water Piping	2001	2,519		20	126	126	494	6
7	Compressor-Valves	2001	1,323		20	66	66	242	7
8	Concrete Chimney	2001	2,575		20	129	129	418	8
9	Pulley & Belt	2001	1,247		20	62	62	197	9
10	Thermocoupler	2001	1,528		20	76	76	242	10
11	Hex Bolt	2001	1,380		20	69	69	213	11
12	Wallpaper Border	2001	2,996		20	150	150	462	12
13	Concrete Pation& Bas	2001	3,800		20	190	190	697	13
14	Custom Diffuser	2001	1,068		20	53	53	209	14
15	Ventilation	2002	3,291		20	329	329	932	15
16	Fire Dampers	2002	25,372		20	2,537	2,537	5,497	16
17	Fire Dampers	2002	1,840		20	184	184	399	17
18	Dialysis Room	2002	14,077		20	1,408	1,408	2,933	18
19	Hvac Room	2002	2,326		20	233	233	698	19
20	Hvac Work	2002	25,413		20	2,541	2,541	7,624	20
21	Water Heaters	2002	10,500		20	1,050	1,050	2,538	21
22	A/C Compressor	2002	7,650		20	638	638	1,594	22
23	Ejector Pump	2002	3,757		20	376	376	908	23
24	Nurse Call	2002	4,578		20	305	305	712	24
25	Chimney Repair	2002	1,017		20	102	102	305	25
26	Generator	2002	1,512		20	151	151	428	26
27	A/C Repair	2002	915		20	92	92	229	27
28	A/C Repair	2002	2,469		20	247	247	617	28
29	Wall Protection	2002	730		20	73	73	183	29
30	Mini-Blinds	2002	816		20	82	82	197	30
31	Hot Water Valves	2002	2,922		20	292	292	633	31
32	Plumbing	2002	1,632		20	163	163	449	32
33	Cubicle Curtains	2002	2,397		20	240	240	699	33
34	TOTAL (lines 1 thru 33)		$ 11,597,484	$ 400,757		$ 362,106	$ (38,651)	$ 3,519,020	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 11,597,484	$ 400,757		$ 362,106	$ (38,651)	$ 3,519,020	1
2	Boiler Work	2003	15,650		20	783	783	1,500	2
3	Boiler Valve	2003	2,576		20	129	129	247	3
4	Exhaust Work	2003	2,541		20	127	127	212	4
5	Electrical Work - Vent	2003	51,700		20	2,585	2,585	4,093	5
6	Vent Alarms (6)	2003	3,894		20	195	195	276	6
7	Vent Alarms (9)	2003	6,352		20	318	318	450	7
8	Kitchen Doors	2003	2,075		20	104	104	138	8
9	Exhaust Work	2003			20				9
10	Piping	2003	2,868		20	143	143	239	10
11	Walk In Freezer	2003	25,014		20	1,251	1,251	1,511	11
12	Vent- Alarm 4	2003	2,824		20	141	141	165	12
13	Vent Alarm-3	2003	2,117		20	106	106	132	13
14	Hvac Work	2003	3,329		20	166	166	194	14
15	Compressor & Condensor - Walk-In Freezer	2003	1,273		20	64	64	127	15
16	Boiler Extras	2003	1,097		20	55	55	105	16
17	Door Screens	2003	1,676		20	84	84	119	17
18	Replace Valves Kitchen Main Sink	2003	1,050		20	53	53	70	18
19	Cubicle Curtains	2003	3,173		20	159	159	198	19
20	Stair Treads	2003	1,046		20	52	52	57	20
21	Exterior Painting	2003	2,415		20	121	121	141	21
22	Repair Sewer & Drains	2003	1,360		20	68	68	113	22
23	Electrical Work	2004	9,956		20	498	498	498	23
24	Vent Wiring	2004	2,299		20	115	115	115	24
25	Vent Wiring	2004	4,496		20	225	225	225	25
26	Paint And Wallpaper	2004	50,465		20	2,313	2,313	2,313	26
27	Painting	2004	12,770		20	585	585	585	27
28	Painting	2004	12,124		20	556	556	556	28
29	Electrical Work	2004	5,510		20	253	253	253	29
30	Steel Door	2004	2,657		20	199	199	199	30
31	Steel Door	2004	2,932		20	220	220	220	31
32	Storage Tank	2004	2,240		20	84	84	84	32
33	Elevator Work	2004	2,045		20	68	68	68	33
34	TOTAL (lines 1 thru 33)		$ 11,839,008	$ 400,757		$ 373,926	$ (26,831)	$ 3,534,223	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 11,839,008	$ 400,757		$ 373,926	$ (26,831)	$ 3,534,223	1
2	Paint & Wallpaper	2004	7,326		20	336	336	336	2
3	Hvac Compressor	2004	15,100		20	315	315	315	3
4	Water Pump	2004	1,320		20	17	17	17	4
5	Pump Repair	2004	1,048		20	79	79	79	5
6	Electrical Work	2004	1,429		20	12	12	12	6
7	Electrical Work	2004	2,080		20	9	9	9	7
8	Elevator Repair	2004	1,265		20	16	16	16	8
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32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,868,576	$ 400,757		$ 374,710	$ (26,047)	$ 3,535,007	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 11,868,576	$ 400,757		$ 374,710	$ (26,047)	$ 3,535,007	1
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4									4
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32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,868,576	$ 400,757		$ 374,710	$ (26,047)	$ 3,535,007	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 11,868,576	$ 400,757		$ 374,710	$ (26,047)	$ 3,535,007	1
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4									4
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32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,868,576	$ 400,757		$ 374,710	$ (26,047)	$ 3,535,007	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 11,868,576	$ 400,757		$ 374,710	$ (26,047)	$ 3,535,007	1
2									2
3									3
4									4
5									5
6									6
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,868,576	$ 400,757		$ 374,710	$ (26,047)	$ 3,535,007	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 11,868,576	$ 400,757		$ 374,710	$ (26,047)	$ 3,535,007	1
2									2
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4									4
5									5
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,868,576	$ 400,757		$ 374,710	$ (26,047)	$ 3,535,007	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 11,868,576	$ 400,757		$ 374,710	$ (26,047)	$ 3,535,007	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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12									12
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,868,576	$ 400,757		$ 374,710	$ (26,047)	$ 3,535,007	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 11,868,576	$ 400,757		$ 374,710	$ (26,047)	$ 3,535,007	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,868,576	$ 400,757		$ 374,710	$ (26,047)	$ 3,535,007	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 11,868,576	$ 400,757		$ 374,710	$ (26,047)	$ 3,535,007	1
2									2
3									3
4									4
5									5
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13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,868,576	$ 400,757		$ 374,710	$ (26,047)	$ 3,535,007	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1994		$ 10,419,509	$ 257,442		$ 297,700	$ 40,258	$ 3,082,449	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 10,419,509	$ 257,442		$ 297,700	$ 40,258	$ 3,082,449	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Allocated From SIR Properties		1993		$ 28,254	$ 897	35	$ 807	$ (90)	$ 9,283	4
5	Allocated From SIR Properties		1993		16,611	527	35	475	(52)	5,458	5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated From Preferred Bookkeeping			1997	20,744	464	20	1,037	573	8,100	9
10	Allocated From Preferred Bookkeeping			1999	165	-	20	8	8	45	10
11	Allocated From Preferred Bookkeeping			2000	1,040	-		52	52	230	11
12											12
13	Allocated From SIR Management, Inc.			1993	12,135	338	20	602	264	7,220	13
14	Allocated From SIR Management, Inc.			1994	38	-	20	2	2	38	14
15	Allocated From SIR Management, Inc.			1995	277	-	20	14	14	130	15
16	Allocated From SIR Management, Inc.			1999	1,318	-	20	66	66	344	16
17	Allocated From SIR Management, Inc.			2000	796	-	20	40	40	187	17
18											18
19	Allocated From SIR Properties - SIR Management			1993	458	2	20	23	21	264	19
20	Allocated From SIR Properties - SIR Management			1994	269	7	20	13	6	141	20
21	Allocated From SIR Properties - SIR Management			1997	106	11	20	5	(6)	45	21
22	Allocated From SIR Properties - SIR Management			1998	1,711	171	20	86	(85)	556	22
23	Allocated From SIR Properties - SIR Management			1999	3,580	358	20	179	(179)	985	23
24	Allocated From SIR Properties - SIR Management			2000	112		20	6	6	14	24
25											25
26	Allocated From SIR Properties - Preferred			1993	269	1	20	13	12	155	26
27	Allocated From SIR Properties - Preferred			1994	158	4	20	8	4	83	27
28	Allocated From SIR Properties - Preferred			1997	63	6	20	3	(3)	27	28
29	Allocated From SIR Properties - Preferred			1998	1,006	101	20	50	(51)	327	29
30	Allocated From SIR Properties - Preferred			1999	2,105	210	20	105	(105)	579	30
31	Allocated From SIR Properties - Preferred			2000	66	-	20	3	3	8	31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
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61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 91,281	$ 3,097		$ 3,597	$ 500	$ 34,219	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 620,309	$ 1,913	$ 54,744	$ 52,831	10	$ 473,747	71
72	Current Year Purchases	130,451	124	12,855	12,731	10	12,855	72
73	Fully Depreciated Assets	292,169	24,293	24,293		10	180,097	73
74								74
75	TOTALS	$ 1,042,929	$ 26,330	$ 91,892	$ 65,562		$ 666,699	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 13,639,496	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 427,087	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 466,602	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 39,515	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,201,706	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 9,937 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 172,097	$		$ 172,097	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			48,873			48,873	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			174,648			174,648	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				179,178		179,178	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental			149,205		132,749	240,963		522,917	13
14	TOTAL			$ 149,205		$ 528,367	$ 420,141		$ 1,097,713	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 13,261	$ 13,262	1
2	Cash-Patient Deposits	61,414	61,414	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,845,018	2,845,018	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		2,040	5
6	Prepaid Insurance	29,308	29,308	6
7	Other Prepaid Expenses	368	368	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	27,310	420,441	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,976,679	$ 3,371,851	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		727,991	13
14	Buildings, at Historical Cost		10,419,509	14
15	Leasehold Improvements, at Historical Cost	541,488	541,488	15
16	Equipment, at Historical Cost	1,489,419	2,224,419	16
17	Accumulated Depreciation (book methods)	(1,305,190)	(5,122,639)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	193,421	305,151	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 919,138	$ 9,095,919	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,895,817	$ 12,467,770	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 362,256	$ 362,256	26
27	Officer's Accounts Payable	28,997	28,997	27
28	Accounts Payable-Patient Deposits	62,881	62,881	28
29	Short-Term Notes Payable	2,245,000	2,245,000	29
30	Accrued Salaries Payable	208,174	208,174	30
31	Accrued Taxes Payable (excluding real estate taxes)	35,417	35,417	31
32	Accrued Real Estate Taxes(Sch.IX-B)		439,800	32
33	Accrued Interest Payable	3,110	3,110	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	127,341	127,341	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,073,176	$ 3,512,976	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule		11,882,500	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 11,882,500	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,073,176	$ 15,395,476	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 822,641	$ (2,927,706)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,895,817	$ 12,467,770	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 960,805	1
2	Restatements (describe):		2
3	Paid In Capital	183,750	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,144,555	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(321,914)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (321,914)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 822,641	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,123,716	1
2	Discounts and Allowances for all Levels	15,083	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,138,799	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,187,958	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,187,958	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	161,364	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,080	19
20	Radiology and X-Ray	17,410	20
21	Other Medical Services	218,614	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 424,468	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	384	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 384	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	23,848	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 23,848	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,775,457	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,528,091	31
32	Health Care	3,836,303	32
33	General Administration	2,136,437	33
	B. Capital Expense		
34	Ownership	1,364,321	34
	C. Ancillary Expense		
35	Special Cost Centers	1,097,713	35
36	Provider Participation Fee	134,506	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,097,371	40
41	**Income before Income Taxes (line 30 minus line 40)****	(321,914)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (321,914)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Cash Basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,199	2,759	$ 104,495	$ 37.88	1
2	Assistant Director of Nursing	1,028	1,048	32,498	31.02	2
3	Registered Nurses	43,370	46,124	1,202,901	26.08	3
4	Licensed Practical Nurses	7,519	8,076	163,061	20.19	4
5	Nurse Aides & Orderlies	95,902	101,200	970,505	9.59	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	7,271	7,616	149,205	19.59	7
8	Rehab/Therapy Aides	5,098	5,397	63,528	11.77	8
9	Activity Director	2,839	2,945	39,229	13.32	9
10	Activity Assistants	9,760	10,125	76,239	7.53	10
11	Social Service Workers	10,806	11,568	105,151	9.09	11
12	Dietician					12
13	Food Service Supervisor	1,959	2,097	26,731	12.75	13
14	Head Cook	4,213	4,607	40,723	8.84	14
15	Cook Helpers/Assistants	22,861	24,723	215,091	8.70	15
16	Dishwashers					16
17	Maintenance Workers	3,697	4,210	53,298	12.66	17
18	Housekeepers	29,300	31,157	228,069	7.32	18
19	Laundry	10,377	10,912	77,806	7.13	19
20	Administrator	1,940	2,322	92,357	39.77	20
21	Assistant Administrator	3,693	3,938	68,801	17.47	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,496	8,810	92,064	10.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	11,696	12,561	210,767	16.78	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	284,024	302,194	$ 4,012,519 *	$ 13.28	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 15,000	01-03	35
36	Medical Director	Monthly	14,400	09-03	36
37	Medical Records Consultant	43	4,128	10-03	37
38	Nurse Consultant	1,213	48,516	10-03	38
39	Pharmacist Consultant	Monthly	3,945	10-03	39
40	Physical Therapy Consultant	187	12,725	10a-03	40
41	Occupational Therapy Consultant	180	12,155	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	4	171	10a-03	43
44	Activity Consultant	Monthly	2,264	11-03	44
45	Social Service Consultant	45	2,313	12-03	45
46	Other(specify) Dir. Food Service	Monthly	24,996	01-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,672	$ 140,613		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	13,676	$ 492,317	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides	28	603	10-03	52
53	TOTAL (lines 50 - 52)	13,704	$ 492,920		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lori Barrish	Administrator	2.04	$ 92,357
Caryl Kiser	Assist. Admin	0	68,801
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 161,158

B. Administrative - Other

Description	Amount
Management Fees - S.I.R. Management	$ 487,816
Ancillary Admin Charges - S.I.R. Management	55,092
Dir. Of Administrative Services - S.I.R. Management	30,876
See Supplemetal Schedule	4,320
TOTAL (agree to Schedule V, line 17, col. 3)	$ 578,104
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 14,985
Personell Planners	Unemployment Consult.	2,310
S.A.S. Architects	Construction Admin.	960
LTC Solutions	MDS Care Plan Software`	1,320
Preferred Bookkeeping	Accounting	27,300
Preferred Bookkeeping	Bookkeeping	88,200
LTC Solutions	Computer Fees	5,880
Morton Cohen	Purchase Consultant	75
ICS Solutions	Website	180
Shefsky & Froelich	Legal Fees	1,750
Michael Best	Legal Fees	3,675
See Supplemetal Schedule		30,566
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 177,201

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 54,442
Unemployment Compensation Insurance	80,444
FICA Taxes	293,913
Employee Health Insurance	70,507
Employee Meals	41,109
Illinois Municipal Retirement Fund (IMRF)*	
401K Plan	6,685
Union Health & Welfare	100,244
Holiday Expense	4,064
Medical Benefits	170
TOTAL (agree to Schedule V, line 22, col.8)	$ 651,578

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	24,095
Health Care Worker Background Check	
(Indicate # of checks performed 125)	1,491
IL Assocation of Health Care Facilities	490
IL Council On LTC	7,520
Licenses & Permits	1,115
Dues & Subscription	100
Allocated From SIR Management	218
See Supplemental Schedule	233
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,262

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,932
Allocated From Preferred	186
Allocated From SIR Management	321
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,439

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? Yes

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council On LTC - $11,311

(3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 10,602 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 134,506
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 41,109 Has any meal income been offset against related costs? N/A Indicate the amount. $ N/A

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.